

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12394

CERTIFICATE OF DEATH

12381

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalburg - Rural		c. LENGTH OF STAY IN 1b 25 years		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Caroline		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalburg - Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Smithville Road						d. STREET ADDRESS Smithville Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anthony		First	Middle	Lost	Dorman	4. DATE OF DEATH Month November	Day 20	Year 19 59			
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	April 18, 1911	9. AGE (In years lost birthday) 48 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Maryland Plastics, Inc.		11. BIRTHPLACE (State or foreign country) Sanderson, Florida		12. CITIZEN OF WHAT COUNTRY U.S.A.					
13. FATHER'S NAME Jerry Dorman				14. MOTHER'S MAIDEN NAME Ellen (maiden name unknown)							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-10-6880		17. INFORMANT Mrs. Miriam F. Dorman, Federalsburg, Md., R.E.D.		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 3 hrs					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DUE TO (b) Hypertension		(c)				10 yrs.					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from _____ to _____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		DATE SIGNED 11-21-59			
ACTUAL SIGNATURE <i>Frank M. Anderson</i>											
PHYSICIAN'S NAME (Type) Frank M. Anderson, M.D.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 22, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Hill Crest Cemetery		22d. LOCATION (City, town, or county) Federalsburg, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE NOV 27 '59		24b. REGISTRAR'S SIGNATURE <i>Carroll S. Kline</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 12382

TO HOSPITAL **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>CAROLINE</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>RIDGELEY</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RIDGELEY</i>		c. LENGTH OF STAY IN 1b <i>LIFE</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RIDGELEY MARYLAND</i>	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>FRED</i>	First <i>H.</i>	Middle <i>Flounders</i>	Last <i>Nov</i>
4. DATE OF DEATH Month <i>Nov</i>	Day <i>20</i>	Year <i>1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 11 1875</i>
9. AGE (In years, months, days, birthdate) <i>84 yrs.</i>	10. IF UNDER 1 YEAR Months <i>3</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
13. FATHER'S NAME <i>RICHARD CARTER Flounders</i>	14. MOTHER'S MAIDEN NAME <i>Elizabeth Murphy</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO.	17. INFORMANT <i>Mr. Fred Flounders</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>199.2</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i> DUE TO <i>(c)</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Extensive leukoplakia of the mouth</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>White Not while at work</i>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Greensboro, Md.</i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Aug. 15</i> , 1959, to <i>Nov. 20</i> , 1959, that I last saw the deceased alive on <i>Nov. 20</i> , 1959, and that death occurred at <i>6:45 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Greensboro, Md.</i> DATE SIGNED <i>Nov. 21, 1959</i>			
ACTUAL SIGNATURE <i>Charles H. Stonesifer</i>	PHYSICIAN'S NAME (Type) <i>Charles H. Stonesifer, M.D.</i>	22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
22b. DATE THEREOF <i>Nov 22/59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>GREENSBORO</i>	22d. LOCATION (City, town, or county) <i>Greensboro, N.C.</i>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>E.V. Moore & Son</i>	ADDRESS <i>Denton, Md.</i>	24a. REC'D BY REGISTRAR DATE <i>NOV 25 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12383

12396

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgely		c. LENGTH OF STAY IN 1b 10 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgely	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alpheus		First Alexander	Middle Horney, Sr.
4. DATE OF DEATH November 7		Month 7	Day 19
5. SEX Male		6. COLOR OR RACE Cau.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH April 27, 1876		9. AGE (In years last birthday) 83	10. IF UNDER 1 YEAR Months 0
11. BIRTHPLACE (State or foreign country) Maryland		12. IF UNDER 24 HRS. Days 0	13. Year 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME Alpheus Horney		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 040-20-0523	
17. INFORMANT Alpheus Horney		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease	
DUE TO 420.0		INTERVAL BETWEEN ONSET AND DEATH Years 15	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic bronchitis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D.
20f. (City or town) Ridgely		(County) Caroline	
(State) Md.			
21. I certify that I attended the deceased from May 1954 to Nov. 7, 1959 that I last saw the deceased alive on Nov. 7, 1959 , and that death occurred at Ridgely M.D. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles H. Winnacott		ADDRESS (Street, city or town, state) Ridgely, Md. 11-7159	
PHYSICIAN'S NAME (Type) CHARLES H. WINNACOTT		DATE SIGNED 11-7-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-10-59	22c. NAME OF CEMETERY OR CREMATORIAL Hillsboro
22d. LOCATION (City, town, or county) Hillsboro, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond B. Rawlings		24a. ADDRESS Hillsboro Md	24b. REGISTRAR'S SIGNATURE Charles S. Thomas
VS A15 (4) 15M 9/54		DATE NOV 10 '59	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12384

12397

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Caroline		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Goldsboro		c. LENGTH OF STAY IN 1b 50 Years		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Goldsboro		
f. STREET ADDRESS None		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Albert	Middle Hudson	Last November 18 1959	
4. DATE OF DEATH	Month November	Day 18	Year 1959	
5. SEX Male	6. COLOR OR RACE Cau.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-29-1879	
9. AGE (In years at birthday) 79 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer Owner	10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Hudson	14. MOTHER'S MAIDEN NAME Louise Reed	Address Altha Hudson Goldsboro, Md.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 217-36-0922	17. INFORMANT Altha Hudson	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177x DUE TO Carcinoma of the Prostate with metastasis to the hip Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Anemia (nutritional)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from alive on and that death occurred at ADDRESS (Street, city or town, state) DATE SIGNED	Feb. 12, 1959, to Nov. 18, 1959, that I last saw the deceased Nov. 17, 1959, 7 A.M., from the causes and on the date stated above. Greensboro, Md. 11/19/59			
ACTUAL SIGNATURE Charles H. Stonesifer, M.D.	PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-20-59	22c. NAME OF CEMETERY OR CREMATORIAL Greensboro	22d. LOCATION (City, town, or county) (State) Greensboro Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. S. Boulaire	ADDRESS Greensboro, Md.	24a. REC'D BY REGISTRAR DATE NOV 23 '59	24b. REGISTRAR'S SIGNATURE Charles S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please ignore carbon copies. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Date of Birth

Cause of Death

Place of Death

Name of Physician

Name of Hospital

Name of Coroner

Name of Mortician

Name of Cemetery

Name of Funeral Home

Name of Attorney

Name of Agent

Name of Relative

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
 1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12385

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalburg		c. LENGTH OF STAY IN 1b Life		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Park Lane		e. STREET ADDRESS Park Lane		
3. NAME OF DECEASED (Type or print) Roberta		First	Middle	
4. DATE OF DEATH November 20 1959		Lost	Month	
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Nov. 25, 1867		9. AGE (In years last birthday) 91 yrs.	10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Federalburg, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Edward F. Davis		
14. MOTHER'S MAIDEN NAME Laura Davis		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		
16. SOCIAL SECURITY NO. None		17. INFORMANT Donald E. Jefferson, Federalburg, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 155.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Primary carcinoma of liver DUE TO (c) Generalized arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 1955, to Nov. 20, 1959, that I last saw the deceased alive on Nov. 20, 1959, and that death occurred at 7:30 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Federalburg, Maryland		DATE SIGNED 11-23-59
ACTUAL SIGNATURE W. K. Knotts M.D.		22. BURIAL, CREMATION, REMOVAL (Specify) Burial Nov. 23, 1959		
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalburg, Maryland		22c. NAME OF CEMETERY OR CREMATORIUM Hill Crest Cemetery		
24a. REC'D BY REGISTRAR DATE NOV 27 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frame		

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12386

1. PLACE OF DEATH o. COUNTY	12399 CAROLINE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE MARYLAND b. COUNTY CAROLINE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgely	c. LENGTH OF STAY IN lb life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Ridgely			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RFD R+1	d. STREET ADDRESS R.F.D. R+1.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Matthew	Middle Johns	4. DATE OF DEATH 11 19 1959			
5. SEX Male	6. COLOR OR RACE Col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 1/12/89	9. AGE (In years last birthday) 70 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER	10b. KIND OF BUSINESS OR INDUSTRY Farmer owner	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Moses Johns	14. MOTHER'S MAIDEN NAME Leah Hutchins		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.			17. INFORMANT Mrs. Carrie Johns, Ridgely Md.	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Denton	(County) Md.	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE EXAMINER'S NAME (Type) DAVISON D. George	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED 11-20-59		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/19/59	22c. NAME OF CEMETERY OR CREMATORIAL Evergreen Cem	22d. LOCATION (City, town, or county) Denton	(State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE James B. D. George, Denton, Md.	ADDRESS	24a. REC'D BY REGISTRAR REC 1 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Evans			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained by the funeral director. To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

12387

1. PLACE OF DEATH a. COUNTY CAROLINE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELY		c. LENGTH OF STAY IN 1b 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS RIDGELY	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) AGNES EMMA		First	Middle
4. DATE OF DEATH Nov. 11 1959		Last	Month Day Year
5. SEX Fem.	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 6-1888
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN GAITLEY		14. MOTHER'S MAIDEN NAME ALICE BRIGHAM	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 420.1		16. SOCIAL SECURITY NO. FRANK LANE RIDGELY	
17. INFORMANT (If yes, give war or dates of service)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Charles Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 1/2 hours	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Coronary Atherosclerosis		DUE TO Arteriosclerosis - Hypertension	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April - 1950 to Nov. 11 1959 that I last saw the deceased alive on Nov. 11 1959 , and that death occurred at Ridgeley, Md. M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Ridgeley, Md.	
ACTUAL SIGNATURE CHARLES H. WINNACOTT		DATE SIGNED 11/14/59	
PHYSICIAN'S NAME (Type) CHARLES H. WINNACOTT		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Nov. 14	
22c. NAME OF CEMETERY OR CREMATORIAL CENTREVILLE		22d. LOCATION (City, town, or county) CENTREVILLE	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane Church Hill, Md.		24a. REC'D BY REGISTRAR DATE NOV 17 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Charles & Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12401

CERTIFICATE OF DEATH

12388

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Caroline		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hickman		c. LENGTH OF STAY IN 1b 9 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION none		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural	
3. NAME OF DECEASED (Type or print) Olen T. Melvin		d. STREET ADDRESS 16	
4. DATE OF DEATH Nov. 2, 1959		Month	Day
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 9, 1884
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years lost birthday) 75 yrs.	10. IF UNDER 1 YEAR Months 7 Days 16 Hours 5 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) store manager- factory work		10b. KIND OF BUSINESS OR INDUSTRY Hickman, Md.	
10c. FATHER'S NAME Thomas Melvin		11. BIRTHPLACE (State or foreign country) Hickman, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. MOTHER'S MAIDEN NAME Cecelia Noble	
14. INFORMANT Mrs. Bessie Melvin		Address Denton, Md. RFD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			
16. SOCIAL SECURITY NO.			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Coronary Thrombosis DUE TO (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z)			
18. INTERVAL BETWEEN ONSET AND DEATH 5 days			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct. 29, 1959 to Nov. 2, 1959 that I last saw the deceased alive on Nov. 2, 1959 , and that death occurred at 6:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>G. Metzler, Jr. M.D.</i>		ADDRESS (Street, city or town, state) Main & Market Sts., Bridgeville, Delaware	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 11/5/1959	
22c. NAME OF CEMETERY OR CREMATORIAL Bloemery Cemetery		22d. LOCATION (City, town, or county) (State) Federalsburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Shawna J. Johnson</i>		ADDRESS Federalsburg, Md.	
24a. REC'D BY REGISTRAR DATE NOV 6 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Traas</i>	

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A. A. — 1 — 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12402

CERTIFICATE OF DEATH

12389

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Greensboro		c. LENGTH OF STAY IN 1b 3 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Easton	
3. NAME OF DECEASED (Type or print) Margaret		First Mae	Middle Patrick
4. DATE OF DEATH 11		Month 19	Day 19
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Separated
8. DATE OF BIRTH 7-10-1875		9. AGE (In years (at birthday) yrs. 84	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew Hickson		14. MOTHER'S MAIDEN NAME ? Neighbors	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Medford J. Benney		Address Centerville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Cerebral Hemorrhage Arteriosclerotic Cardiovascular Dis. with hypertension General Arteriosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED White Nat white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 1, 1958</u> , to <u>Nov. 19, 1959</u> , that I last saw the deceased alive on <u>Nov. 18, 1959</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Greensboro, Md.	
ACTUAL SIGNATURE Charles H. Stonesifer M.D.		DATE SIGNED Nov. 20 '59	
PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-21-59	
22c. NAME OF CEMETERY OR CREMATORIUM Chesterfield		22d. LOCATION (City, town, or county) (State) Centerville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulaire Greensboro, Md.		ADDRESS	
		24a. REC'D BY REGISTRAR DATE NOV 23 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12403

CERTIFICATE OF DEATH

12390

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Caroline		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalburg		c. LENGTH OF STAY IN 1b 10 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalburg				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Denton Road				d. STREET ADDRESS Denton Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Harrison		First	Middle	Lost	4. DATE OF DEATH November	Month	Day	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Septemeber 14, 1888	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Caroline Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Frank Trice				14. MOTHER'S MAIDEN NAME Martha Rosser				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-30-8984		17. INFORMANT Mrs. Ralph D. Lord, Federalsburg, Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH Primary Adeno Carcinoma being July 21-59		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)
21. I certify that I attended the deceased from <u>7-21-</u> , 1959, to <u>NOV-2</u> , 1959, that I last saw the deceased alive on <u>Nov. 2</u> , 1959, and that death occurred at <u>1:30P M</u> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Federalsburg Md.		
ACTUAL SIGNATURE W. E. Lennon		M.D.				DATE SIGNED 1959		
PHYSICIAN'S NAME (Type) W. E. Lennon MD								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 4, 1959		22c. NAME OF CEMETERY OR CREMATORIUM Hill Crest Cemetery		22d. LOCATION (City, town, or county) Federalsburg, Maryland		(State)
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland		ADDRESS J. J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR DATE NOV 5 '59		24b. REGISTRAR'S SIGNATURE G. L. Johnson		

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